National Transportation Safety Board

# FACTUAL REPORT AVIATION

| | |
|---|---|
| NTSB ID: LAX00FA310 | Aircraft Registration Number: N923BA |
| Occurrence Date: 08/25/2000 | Most Critical Injury: Fatal |
| Occurrence Type: Accident | Investigated By: NTSB |

## Location/Time

| Nearest City/Place | State | Zip Code | Local Time | Time Zone | |
|---|---|---|---|---|---|
| Hilo | HI | 96720 | 1735 | HST | |

Airport Proximity: Off Airport/Airstrip

Distance From Landing Facility: 3.1

## Aircraft Information Summary

| Aircraft Manufacturer | Model/Series | Type of Aircraft |
|---|---|---|
| Piper | PA-31-350/PA-31-350 | Airplane |

Revenue Sightseeing Flight: Yes

Air Medical Transport Flight: No

## Narrative

Brief narrative statement of facts, conditions and circumstances pertinent to the accident/incident:

HISTORY OF FLIGHT

On August 25, 2000, at 1735 Hawaiian standard time, a Piper PA-31-350 twin engine airplane, N923BA, operated as Big Island Air flight number BI 57, was substantially damaged during an emergency ditching in the Pacific Ocean following a loss of engine power while in cruise flight. The pilot was attempting to land at the Hilo International Airport, Hilo, Hawaii, when the ditching occurred. One passenger received fatal injuries, while the commercial pilot and remaining 7 passengers received minor injuries. Big Island Air, Inc., was operating the airplane as a nonscheduled sightseeing tour under 14 CFR Part 135, when the accident occurred. The local flight originated from Kailua-Kona, Hawaii, at 1700, and was en route to the Hilo area with a planned return to Kona, without landing at Hilo. Visual meteorological conditions prevailed at the time of the accident and a visual flight rules flight plan was filed and activated.

The pilot reported that he was at 1,000 feet mean sea level (msl) near Laupahoehoe, Hawaii, when he felt the airplane yaw to the right, and noted that the right engine's manifold pressure had dropped to about 25 inches. He immediately switched from the right main fuel tank to the right auxiliary fuel tank and turned on the fuel boost pump. He then moved the throttles, propellers, and mixture controls full forward, and identified the right engine was not producing thrust. He shutdown the right engine by reducing the throttle to idle, bringing the mixture control into idle cutoff, and then by moving the propeller control into the feather position. He noted, however, that the right propeller continued to rotate intermittently after shutdown.

At the same time the pilot noted the power loss, at least two passengers indicated to him that a fire was visible through the louvers on the right engine cowling. The pilot announced that they were going to land at the Hilo International Airport (ITO), which was 23 miles ahead.

As the airplane deviated toward Hilo, the pilot noted that with the airspeed at blue line (Vyse) he was unable to maintain altitude. The airplane continued to descend between 100 and 50 feet per minute. He checked to ensure that the cowl flaps were closed on both engines, and noted that the left engine was producing 41.5 inches of manifold pressure with the left propeller in the full forward position.

Considering the distance to the airport, the pilot estimated that he would not be able to reach land or the airport. He then instructed the passengers to don their life vests and briefed them to prepare for ditching. He made MAYDAY distress calls to the ITO control tower and to the Honolulu Flight Service Station. He also set the transponder to squawk 7700.

About 250 feet msl and 5 miles from the airport, the pilot began configuring the airplane for ditching. He slowed the airplane and gradually added full flaps, keeping full power on the left engine. He felt the tail of the airplane touch the water; followed by a jolt that momentarily

National Transportation Safety Board

**FACTUAL REPORT**
**AVIATION**

NTSB ID: LAX00FA310

Occurrence Date: 08/25/2000

Occurrence Type: Accident

Narrative (Continued)

stunned him. When he fully regained his senses, the water in the cockpit was already chest high. He opened the left pilot door and noticed the right front seat passenger climbed across him and exited first.

After exiting, the pilot moved to the rear main cabin door (located on the left side of the cabin) to assist the passengers. The right front seat passenger remained by the left cockpit door to assist any passengers who might be using that exit.

A passenger reported that water pressure against the right emergency window exit prevented its use. The airplane began to take on water immediately upon landing. As the nose sank first, the airplane began a gradual roll to the right, disappearing below the water within 60 seconds. The pilot attempted to dive below the water to check for any remaining passengers but reported that the murky water restricted his vision.

The pilot signaled for the passengers to remain in a group and within about 15 minutes a Hilo fire department helicopter and rescue personnel were on the scene. One passenger was determined to be missing and an unsuccessful search was initiated. Subsequently, the missing passenger was located in the airplane.

The following day the airplane was located by U.S. Coast Guard sonar under 80 feet of water. The site was 3.1 miles from ITO and on a 123-degree magnetic bearing to the airport. The airplane was recovered on August 27, 2000, and secured in the Civil Air Patrol hangar at ITO.

PERSONNEL IFORMATION

The commercial pilot held ratings in single engine land, multiengine land, and instrument airplanes. He also held a flight instructor rating for single engine airplane. He was issued a first-class medical certificate on July 7, 2000, with no limitations. According to the Pilot/Operator Aircraft Accident Report that the pilot submitted, he reported having accumulated a total of 2,067 hours of flight time, of which 1,096 hours were accumulated in multiengine airplanes.

According to Big Island Air records, the pilot was hired on September 13, 1999, and underwent basic indoctrination, ground instruction, flight instruction, and general emergency training between September 15, and 21, 1999. The pilot passed the FAR Part 135 Airman Competency/Proficiency Check on September 21, 1999. The pilot accumulated approximately 465.3 hours in the PA-31-350 after he became a line pilot for Big Island Air.

METEOROLOGICAL INFORMATION

At 1753, the Hilo, Hawaii, weather observation facility reported the wind from 080 degrees at 8 knots; visibility 10 statute miles; a few clouds at 2,300 feet agl; temperature 26 degrees Celsius; dew point 21 degrees Celsius; and an altimeter setting of 30.00 inches of mercury.

AIRCRAFT INFORMATION

The twin engine Piper Chieftain airplane was powered by two TEXTRON Lycoming 350-horsepower TIO-540-J2BD turbo-charged engines and two 3-bladed, constant-speed, full-feathering Hartzell propellers. The left engine (serial number RL-9827-61A) rotates clockwise and the right engine (serial number L-1650-68A) rotates counterclockwise as viewed from the pilot seat. Lycoming recommends an engine overhaul interval of 1,600 hours.

The propeller blade pitch is adjusted via the combination of nitrogen or air pressure, a spring, blade counterweights and governor-regulated oil pressure. The nitrogen or air pressure, spring and blade counterweight force are utilized to move the blades to the high pitch (decreased rpm) and feathered positions. The opposing governor-regulated oil pressure moves the blades to the low

National Transportation Safety Board

**FACTUAL REPORT**
**AVIATION**

NTSB ID: LAX00FA310

Occurrence Date: 08/25/2000

Occurrence Type: Accident

Narrative (Continued)

pitch (increased rpm) positions. Moving the propeller control lever aft decreases the propeller rpm as the propeller governor decreases the oil pressure to the hub, and the air pressure, spring, and blade counterweights move the propeller blades to the high pitch or, if selected, the feathered position.

The PA-31-350 Pilot Information Manual's (PIM) Emergency Procedures section supplies recommended procedures for coping with various types of emergencies. The recommended emergency procedures for an ENGINE FIRE IN FLIGHT are as follows:

"Fire wall fuel shutoff.....OFF
Throttle.....Idle
Propeller.....FEATHER
Mixture.....Idle Cut-off
Inoperative Engine.....Secure
If fire persists, Airspeed.....Increase in attempt to blow out fire.
Land at nearest suitable airport."

The ENGINE SECURING PROCEDURE (FEATHERING PROCEDURE) instructs the pilot to:

"Throttle.....close
Propeller.....FEATHER (1000 RPM min.)
Mixture.....IDLE CUT-OFF
Cowl flaps.....close
Air conditioner.....OFF
Magneto switch.....OFF
Emergency fuel pump.....OFF
Fuel selector.....OFF (detent)
Fuel boost pump CB.....pulled
Alternator CB switch.....OFF
Prop. Sync.....OFF
Electrical load.....reduced
Crossfeed.....if required."

The PIM also recommends that the pilot attain and maintain 106 knots for the best rate of climb with an engine inoperative and instructs pilots to bank the airplane approximately 5 degrees into the operative engine following an ENGINE FAILURE DURING FLIGHT (Above 76 KIAS).

Review of the accident flight's weight and balance data, supplied by the operator, indicated that they weighed the passengers and baggage and calculated a takeoff weight of 7,107 pounds and a center of gravity placement of 129.50 inches aft of datum. The operator listed the maximum takeoff weight as 7,368 pounds and indicated that the center of gravity limits at the takeoff weight was 126.50 inches aft of datum to 135.00 inches aft of datum.

The Piper Chieftain performance charts indicate that with a pressure altitude between sea level and 1,000 feet (1,500 feet to 2,700 feet density altitude) and a gross weight of 7,107 pounds, the airplane should have been able to maintain a climb of approximately 150 to 175 feet per minute with one engine inoperative. The single engine climb performance chart stipulates that the operative engine be set at maximum climb power and the cowl flap should be open, and the inoperative engine should be feathered, the cowl flap closed, and the landing gear and flaps should be retracted. In addition, the performance chart stipulates that the pilot incorporate a 5-degree bank toward operative engine.

At the time of the accident, the aircraft had accumulated approximately 3,510.6 hours, and the engines had accumulated approximately 1,298.3 and 386.8 hours on the left and right engine respectively, since their last overhaul. The right engine underwent its last overhaul on March 10, 2000, at the Textron Lycoming overhaul facility in Williamsport, Pennsylvania.

National Transportation Safety Board

**FACTUAL REPORT**
**AVIATION**

NTSB ID: LAX00FA310

Occurrence Date: 08/25/2000

Occurrence Type: Accident

Narrative (Continued)

The operator placed the accident airplane on an Approved Aircraft Inspection Program (AAIP), which consisted of eight inspections that were conducted at 50-hour intervals. At the 400-hour interval, the airplane would have undergone all eight phases of the AAIP. In each calendar year, the aircraft must complete all eight inspection phases. Therefore, if, at 1 year from the date of the first phase inspection, at least one complete cycle of phases 1 through 8 has not been completed, all remaining inspections would become due.

Review of the aircraft maintenance records revealed that the aircraft underwent inspection phase seven on August 21, 2000, or 18.3 hours prior to the accident. During the phase seven inspection, the engines underwent an oil change, which included the change of the oil filter. According to the operator's inspection criteria, the oil lines and fittings are to be examined for "leaks, security, chafing, dents, and cracks." In addition, the right engine was inspected in accordance with Lycoming Mandatory Service Bulletin (MSB) No. 543, which called for the examination of the oil filter converter plate and its gasket (part number LW-13388) every 50 hours.

Lycoming MSB No. 543 instructed the mechanic to visually inspect for evidence of oil leakage from the oil filter converter plate gasket and for evidence of the extrusion of the gasket every 50 hours. The MSB was issued on July 24, 2000, after the manufacturer received reports of certain oil filter converter plate gaskets extruding around the oil filter converter plate. The protruding or swelling of the gasket allowed oil to leak and spray from between the plate and the accessory housing. This condition resulted in a loss of engine oil and subsequent in-flight fire (NTSB Accident No. ANC00IA063, accident date June 1, 2000). The MSB encompassed TIO-540-J2BD engine models that were new, remanufactured, or overhauled, and "were shipped [from the Lycoming factory] after January 1, 1998."

The Safety Board material's engineer assigned to ANC00IA063, in conjunction with a material's engineer from Textron Lycoming, conducted a series of tests on new converter plate gaskets. A new converter plate gasket was subjected to Aeroshell 15W50 engine oil that was heated to 245 degrees F. After about 290 hours, the gasket material displayed signs of deterioration similar to that of the incident gasket.

Procurement personnel from Textron Lycoming contacted the manufacturer of the converter plate gaskets. A subsequent investigation revealed that the manufacturer had recently changed gasket suppliers, which resulted in variance from the required gasket specifications dictated by Textron Lycoming.

WRECKAGE AND IMPACT INFORMATION

On August 28-30, 2000, a Safety Board investigator conducted a postaccident inspection of the airplane wreckage with a Federal Aviation Administration (FAA) inspector, and air safety investigators from Textron Lycoming and New Piper Aircraft. The airplane sustained extensive damage from the recovery process (as compared to an underwater video taken of the wreckage prior to its removal from the ocean). During the recovery process, the empennage separated from the airframe, the vertical stabilizer and rudder were crushed down, and the cockpit and cabin area sustained crushing damage in the downward direction and sections of the cabin structure were torn, exposing the interior. It was noted that the landing gear were retracted and the flaps were extended.

Investigators noted soot and fire damage extending on the bottom side of the right wing from the engine cowling area aft to the trailing edge of the flap and engine nacelle. The engine cowling was removed and it was noted that the fire damage concluded at the oil filter. A film of oil was noted over areas of the accessory section. A closer inspection of the oil filter converter plate (located behind the oil filter) revealed the extruded remains of the oil filter converter plate gasket. The oil filter was found safety wired and secure along with the converter plate. The oil filter and its converter plate were then removed. It was noted that a 3/16-inch area of the gasket

National Transportation Safety Board

**FACTUAL REPORT**
**AVIATION**

NTSB ID: LAX00FA310

Occurrence Date: 08/25/2000

Occurrence Type: Accident

Narrative (Continued)

material was missing. The missing section of gasket material was situated at the 9 o'clock position, as viewed looking at the rear of the engine. The remaining gasket material appeared swollen and was soft and spongy to the touch, similar to the gasket found in the ANC00IA063 incident.

The right propeller remained attached to the right engine and investigators noted that while the blades were secure in their grips, the blade angles did not correspond to a feathered position. The propeller blades were cutoff near their hubs to facilitate shipment and were sent, along with the propeller governors, to the manufacturer's facility for further examination.

TESTS AND RESEARCH

The propellers were examined on October 16, 2000, under the supervision of an FAA inspector. There was zero air pressure in the right propeller cylinder, but it had been relieved during the propeller removal. Air pressure was applied to the cylinder and it held air for several minutes. The pitch change mechanism was intact and operable. The low pitch and feather stops were intact and unremarkable. The preload plates were intact and unremarkable and did not display any impact markings. The counterweights and blade pitch change knobs were intact on all three blades.

Both propellers and their respective governors displayed no internal or external problems that would have prevented their operation.

SURVIVAL FACTORS

The airplane was configured with two forward facing seats in the cockpit and four sets (eight total) of forward facing passenger seats on either side of the cabin divided by an aisle that ran the length of the cabin. There were three exits in the aircraft; the main cabin entrance/exit door (located at the rear and left side of the cabin), the over wing emergency exit (located on the right side of the cabin), and the pilot door (located adjacent to the left side pilot seat in the cockpit).

According to the pilot, he briefed the passengers before they boarded the airplane by gathering them around the aft entry door of the airplane. He demonstrated the use of the airplane's seatbelts, the air sickness bags, emergency briefing cards, and the life vests (which were located in the seat pocket in front of each seat). He also told them to keep their seatbelts "nice and tight," and added that they should read the briefing card regarding each exit location and its operation. He pointed out each exit and where they were located and how they operated.

The pilot reported having informed the passengers about how to don their life vests if an emergency ditching was required; however, he did not physically demonstrate the use of an actual life vest. He also stated that he informed the passengers to pull down on the red inflation tabs to inflate the vest and if that did not inflate the vest, the passengers should blow through the inflation tubes near the top of the vest. He added that he instructed the passengers that they should only inflate the life vests after they departed the airplane.

After the pilot started the engines, he informed the passengers that he would not be narrating the tour until they were at cruise altitude. He reported that he asked the passengers to review the emergency briefing card.

During the emergency, after the pilot realized that the airplane would not make it to the Hilo International Airport, he told the passengers that he wanted everyone to put on their life vests and wanted them to assume the crash positions. When the airplane touched down in the water (approximately 75 knots) the pilot felt the airplane's tail touch down in the water twice and then he felt the airplane slam into the water. He reported that he briefly "saw stars" and his vision went black for a short time. He reported that he had his lap belt and shoulder harness on for

National Transportation Safety Board

**FACTUAL REPORT**
**AVIATION**

NTSB ID: LAX00FA310

Occurrence Date: 08/25/2000

Occurrence Type: Accident

Narrative (Continued)

takeoff, but he released the shoulder harness during cruise flight and did not secure it prior to ditching the airplane.

After the airplane impacted the water, the pilot noticed water up to his chest. He immediately opened the pilot door and the passenger located in the right cockpit seat "flew past him" and exited through the door. The pilot released his seat belt and followed behind the passenger. The pilot then crossed over the left wing and assisted the passengers in opening the main cabin door. Once everyone (with the exception of the passenger located in the seat aft of the right cockpit seat, seat number 4) exited the airplane, the pilot kept everyone in a group in the water while they waited for rescue personnel. They then noticed that one of the passengers was missing; however, the airplane was already submerged and sinking underwater.

According to rescue effort logs, rescue personnel were informed of the distressed airplane at 1731, and were told that the airplane was headed for ITO. At 1737, rescue personnel were informed by the air traffic control personnel that the airplane would be ditching and the rescue units were diverted to the bay near Hilo. At 1746, a rescue helicopter offloaded two rescue personnel in the water near the survivors. Four of the passengers were rescued by helicopter, and the rest were rescued by boat at 1808. The pilot and passengers were taken to an onshore hazmat area where fuel and salt water were rinsed off with soap and water. They were then transported to the hospital for examination.

Five of the surviving passengers returned a Safety Board Survival Factors/Aircraft Passenger Questionnaire, which included a written statement section. One passenger did not return the questionnaire; however, he was interviewed by investigators. According to the five returned questionnaires, only one passenger reported having read the briefing card. The emergency section of the briefing card included information regarding the emergency exit locations and their operation. According to the emergency briefing card, the main cabin door, window exit, and pilot door all required persons to push out on the exit. A few of the passengers reported that the right side overwing window exit would not open due to the pressure of the water. Four of the passengers exited through the main cabin door while four people (including the pilot) exited through the pilot's door.

One passenger reported donning her life vest over the headset that was provided for each of the passengers. Her husband, who was seated next to her, unplugged the headset because "the earphone wire was tangled in her life jacket." It was noted that the pilot did not brief the passengers to put the life vest on under the headset wires to prevent entanglement. The pilot stated that it was not standard operating procedure at Big Island Air to brief passengers regarding the headset and life jacket interface.

The husband of the passenger who died indicated that she "was not a swimmer" but he was. He added that after the airplane impacted the water, he looked at his wife and thought she looked frightened. The passenger seated in front of her said that he heard her inflate her life vest after they impacted the water. He added that once he exited the airplane he looked back and saw her sitting still, with her seatbelt still fastened, and her life vest inflated.

Review of videotape taken by aircraft recovery divers revealed that the aircraft cabin structure remained intact and displayed little or no damage. The main exit door was opened. The seats were intact and not damaged.

Life Jackets under the AAIP, are visually inspected every 30 days for physical damage and for 12-month certification date. Each life vest was to be returned to an FAA approved repair station for inspection and recertification each 12 months from the date of the last inspection marked on the life vest. It is not known when the last inspection on the life vests took place. After aircraft recovery, it was noted that one life jacket was found entangled with one of the passenger headset.

National Transportation Safety Board

**FACTUAL REPORT**
**AVIATION**

NTSB ID: LAX00FA310

Occurrence Date: 08/25/2000

Occurrence Type: Accident

Narrative (Continued)

ADDITIONAL INFORMATION

On August 30, 2000, Textron Lycoming issued a revised MSB (MSB, No. 543A), which required the replacement of the oil filter converter plate gasket, every 50 hours. In addition, the updated MSB encompassed numerous Lycoming engine models that were suspected of having the faulty oil filter converter plate gasket installed.

On September 5, 2000, the FAA Burlington, Massachusetts, Certification Office, issued an emergency airworthiness directive (AD) requiring: "All Textron Lycoming 320, 360, 540, 541, and 720 series engines will be inspected in accordance with the Textron Lycoming's mandatory service bulletin (MSB) 543A, dated August 30, 2000, and Textron Lycoming's Service Instruction 1453, dated May 9, 1991, before further flight."

**National Transportation Safety Board**

# FACTUAL REPORT AVIATION

NTSB ID: LAX00FA310

Occurrence Date: 08/25/2000

Occurrence Type: Accident

## Landing Facility/Approach Information

| Airport Name | Airport ID: | Airport Elevation | Runway Used | Runway Length | Runway Width |
|---|---|---|---|---|---|
| Hilo International | KOA | 38 Ft. MSL | | | |

Runway Surface Type: Unknown

Runway Surface Condition: Unknown

Approach/Arrival Flown: NONE

VFR Approach/Landing: Forced Landing

## Aircraft Information

| Aircraft Manufacturer | Model/Series | Serial Number |
|---|---|---|
| Piper | PA-31-350/PA-31-350 | 31-8252024 |

Airworthiness Certificate(s): Normal

Landing Gear Type: Retractable - Tricycle

| Amateur Built Acft? | Number of Seats: | Certified Max Gross Wt. | Number of Engines: |
|---|---|---|---|
| No | 10 | 7000 LBS | 2 |

| Engine Type: | Engine Manufacturer: | Model/Series: | Rated Power: |
|---|---|---|---|
| Reciprocating | Lycoming | TIO-540-J2BD | 350 HP |

- Aircraft Inspection Information

| Type of Last Inspection | Date of Last Inspection | Time Since Last Inspection | Airframe Total Time |
|---|---|---|---|
| AAIP | 08/2000 | 18 Hours | 3492.3 Hours |

- Emergency Locator Transmitter (ELT) Information

| ELT Installed?/Type | ELT Operated? | ELT Aided in Locating Accident Site? |
|---|---|---|
| Yes / | No | No |

## Owner/Operator Information

| Registered Aircraft Owner | Street Address | City | State | Zip Code |
|---|---|---|---|---|
| Tom Beard | P.O. Box 1476 | Kailua-Kona | HI | 96745 |

| Operator of Aircraft | Street Address | City | State | Zip Code |
|---|---|---|---|---|
| Big Island Air, Inc. | P.O. Box 1476 | Kailua-Kona | HI | 96745 |

Operator Does Business As: Big Island Air, Inc.

Operator Designator Code: BIAA

- Type of U.S. Certificate(s) Held:

Air Carrier Operating Certificate(s): On-demand Air Taxi

Operating Certificate:

Operator Certificate:

Regulation Flight Conducted Under: Part 135: Air Taxi & Commuter

Type of Flight Operation Conducted: Unknown;Non-scheduled; Domestic; Passenger Only

National Transportation Safety Board

# FACTUAL REPORT AVIATION

NTSB ID: LAX00FA310

Occurrence Date: 08/25/2000

Occurrence Type: Accident

## First Pilot Information

| Name | City | State | Date of Birth | Age |
|---|---|---|---|---|
| On File | On File | On File | On File | 33 |

Sex: M | Seat Occupied: Left | Occupational Pilot? Civilian Pilot | Certificate Number: On File

Certificate(s): Commercial

Airplane Rating(s): Multi-engine Land; Single-engine Land

Rotorcraft/Glider/LTA: None

Instrument Rating(s): Airplane

Instructor Rating(s): None

Current Biennial Flight Review? 09/1999

Medical Cert.: Class 1 | Medical Cert. Status: Valid Medical--no waivers/lim. | Date of Last Medical Exam: 07/2000

| - Flight Time Matrix | All A/C | This Make and Model | Airplane Single Engine | Airplane Mult-Engine | Night | Instrument Actual | Instrument Simulated | Rotorcraft | Glider | Lighter Than Air |
|---|---|---|---|---|---|---|---|---|---|---|
| Total Time | 2067 | 465 | 971 | 1096 | | | | | | |
| Pilot In Command(PIC) | 1917 | | | | | | | | | |
| Instructor | 500 | | | | | | | | | |
| Instruction Received | | | | | | | | | | |
| Last 90 Days | 163 | | | | | | | | | |
| Last 30 Days | 64 | | | | | | | | | |
| Last 24 Hours | 5 | | | | | | | | | |

Seatbelt Used? Yes | Shoulder Harness Used? Yes | Toxicology Performed? No | Second Pilot? No

## Flight Plan/Itinerary

Type of Flight Plan Filed: VFR

| Departure Point | State | Airport Identifier | Departure Time | Time Zone |
|---|---|---|---|---|
| Kailua-Kona | HI | KOA | 1700 | HST |

| Destination | State | Airport Identifier |
|---|---|---|
| Local Flight | | |

Type of Clearance: VFR

Type of Airspace: Class D

## Weather Information

Source of Wx Information:

Unknown

**National Transportation Safety Board**

# FACTUAL REPORT AVIATION

NTSB ID: LAX00FA310

Occurrence Date: 08/25/2000

Occurrence Type: Accident

## Weather Information

| WOF ID | Observation Time | Time Zone | WOF Elevation | WOF Distance From Accident Site | Direction From Accident Site |
|---|---|---|---|---|---|
| ITO | 1653 | HST | 38 Ft. MSL | 3 NM | 123 Deg. Mag. |

Sky/Lowest Cloud Condition: Scattered 2300 Ft. AGL

Condition of Light: Day

Lowest Ceiling: Broken 3400 Ft. AGL

Visibility: 10 SM

Altimeter: 30.08 "Hg

Temperature: 26 °C

Dew Point: 21 °C

Weather Conditions at Accident Site: Visual Conditions

Wind Direction: 80

Wind Speed: 12

Wind Gusts:

Visibility (RVR): Ft.

Visibility (RVV) SM

Precip and/or Obscuration:

## Accident Information

Aircraft Damage: Substantial

Aircraft Fire: In-flight

Aircraft Explosion None

| - Injury Summary Matrix | Fatal | Serious | Minor | None | TOTAL |
|---|---|---|---|---|---|
| First Pilot | | | 1 | | 1 |
| Second Pilot | | | | | |
| Student Pilot | | | | | |
| Flight Instructor | | | | | |
| Check Pilot | | | | | |
| Flight Engineer | | | | | |
| Cabin Attendants | | | | | |
| Other Crew | | | | | |
| Passengers | 1 | | 7 | | 8 |
| - TOTAL ABOARD - | 1 | | 8 | | 9 |
| Other Ground | 0 | 0 | 0 | | 0 |
| - GRAND TOTAL - | 1 | 0 | 8 | | 9 |

National Transportation Safety Board

**FACTUAL REPORT**
**AVIATION**

NTSB ID: LAX00FA310

Occurrence Date: 08/25/2000

Occurrence Type: Accident

## Administrative Information

Investigator-In-Charge (IIC)

Robert R. Crispin

Additional Persons Participating in This Accident/Incident Investigation:

Dennis L Noll
Federal Aviation Administration
Honolulu, HI

Charles R Little
New Piper Aircraft
Chino Hills, CA

Mark W Platt
Textron Lycoming
Van Nuys, CA